

SECTION 4

PRIOR AUTHORIZATION

Prior Authorization

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional Medicaid Program, expanded services are available to recipients under the age of 21 through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request must be completed and mailed to Infocrossing Healthcare Services, Inc., P.O. Box 5700, Jefferson City, MO, 65102. Providers should keep a copy of the original PA request form as the form is not returned to the provider.
- The provider performing the service must submit the PA request form. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.
- PA requests are not to be submitted for services prescribed to an ineligible patient. State Consultants review for medical necessity only and do not verify a patient's eligibility.
- Expanded HCY (EPSDT) services are limited to patients under the age of 21 and are **not** reimbursed for patients 21 and over even if prior authorized.
- Payment is **not** made for services initiated before the approval date on the PA request form or after the authorization deadline. For services to continue after the expiration date of an existing PA, a new PA request **must** be completed and mailed to Infocrossing Healthcare Services.
- An approved prior authorization **does not** guarantee payment.

Whether the prior authorization is approved or denied, a disposition letter will be mailed to the provider containing all of the detail information related to the PA request. All other documentation submitted with the PA request will not be returned. Requests for changes to an approved PA must be indicated on the disposition letter and submitted to Infocrossing at the address stated above. A new PA request for changes to an approved PA should not be submitted. Denied or incomplete PA requests must be resubmitted to Infocrossing with additional documentation as needed. Providers do not have to obtain a new PA request form signed by the prescribing practitioner, but may submit a legible copy of the original PA request.

Instructions for completing the PA request form are found in Section 8 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms. Instructions are also self-contained on the back of the PA request form.



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Return to: Infocrossing Healthcare Services, Inc.
PO Box 5700
Jefferson City, MO 65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1. _____	2. NAME (LAST, FIRST, M.I.) _____	3. DATE OF BIRTH _____
4. ADDRESS (STREET, CITY, STATE, ZIP CODE) _____		5. MEDICAID NUMBER _____
6. PROGNOSIS _____	7. DIAGNOSIS CODE _____	8. DIAGNOSIS DESCRIPTION _____
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE. _____		

II. HCY (EPSDT) SERVICE REQUEST**(MAY REQUIRE PLAN OF CARE)**

10. DATE OF HCY SCREEN _____	11. SCREENING <input type="checkbox"/> FULL <input type="checkbox"/> INTERPERIODIC <input type="checkbox"/> PARTIAL	12. TYPE OF PARTIAL HCY SCREEN _____
13. SCREENING PROVIDER NAME _____	14. PROVIDER NUMBER _____	15. TELEPHONE NUMBER () _____

III. SERVICE INFORMATION**FOR STATE USE ONLY**

16. REF. NO.	17. PROCEDURE CODE	18. MODIFIERS	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS _____

27. MEDICAID PROVIDER NUMBER _____

28. SIGNATURE _____

DATE _____

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME _____

30. TELEPHONE
() _____

31. ADDRESS _____

32. DATE DISABILITY BEGAN _____

33. PERIOD OF MEDICAL NEED IN MONTHS _____

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF PRESCRIBING PHYSICIAN/PRACTITIONER _____

DATE _____

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin

DATE _____

REVIEWED BY SIGNATURE ► _____

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipient's Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipient's current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipient's address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipient's prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening – Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Procedure Code – Enter the procedure code(s) for the services being requested.
18. Modifier – Enter the appropriate modifier(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter the specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary.
Do not use another Prior Authorization Form.

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid identification number.
28. Signature/Date – The provider of services should sign the request and indicate the date the form was completed.
(Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner – The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.